Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Medicines Optimisation Group (MOG)

Held on 20 October 2016, 1.30pm-3.30pm, Conference Room, Jenner House

These Minutes are presented for **Approval**

Members Present	
Rebecca Eastley, Chair (RE) Valerie McElhinney (VMc) Lucie Ralph (LR) Ellen Yankah (EY) Jeremy Wallace (JW) Terri Turner (TT) Jane Bolster (JB) Chris May (CM)	Maria-Paloma Sequeiros (M-PS) Prabhakaran Naveen (PN) Shirley Bickers (SB) James Severs (JS) via teleconference Phil Harding (PH) Sally Squires (SS) via teleconference Sherin Mehany (SM)
Staff In Attendance	
Christine Dean, Business Coordinator	
MOG/16/01 Apologies	
Jon Hayhurst (JH) Dr Ramesh Swindon representative James Eldred	Pete Wood Bill Bruce-Jones Martin Marlowe

MOG/16/02 Declarations of Interest

Declaration of Interest forms are to be sent out to the attendees to complete and return for filing.

MOG/16/03 Minutes & Actions

One amendment to the minutes of 30 June Page 2 agenda item MOG/16/23 Shared Care Protocols/Agreement – *Medications remain Amber with NICE should be amended to read Medications remain amber with the* ***Formulary***

With the above amendment made the minutes are recorded as an accurate record

MOG16/04 NICE Compliance – Medicines Optimisation Group Membership

The membership of the group was discussed. The membership list must be accurate to comply with NICE guidelines.

The current Terms of Reference lists the following membership:

Medical Director; Rebecca Eastley (Chair)

Chief Pharmacist; Val McElhinney (Deputy Chair)

Finance Representative – TBC

Chair of MIRG; Chris May

Sponsor: Chair

Corporate & Delivery Manager; TBC

Service User Representative; TBC

3 x Specialist Clinical Pharmacists

Non-Medical Prescriber Lead; Phil Harding

Head of Nursing; Jane Bolster

Clinical Audit; Lucie Ralph

Representative from each LDU

- North Somerset; Dr Sheirin Mehany
- BANES; Dr P Naveen
- Wiltshire, Dr Jeremy Wallace
- South Glos; Dr Maria-Paloma Sequeiros
- Swindon; Theresa Turner, pharmacist represented Swindon at the meeting
- Bristol; Dr Ivan Nikolov
- Secure; TBC
- Specialised; TBC

CCG/Heads of medicines management representative (BNSSG, Wiltshire) TBC

MOG/16/05 Procedures / Guidelines

Implementing Resus Council (UK) Quality Standards for CPR Practice and Training; Mental Health IP Care - Emergency Drugs

The Trust Head of Resuscitation (JS) informed the group that there is inconsistency in the availability of emergency drugs stocked in the Trust. A draft paper has been written by JS detailing the current situation. He highlighted the need to standardise practice and proposed a review of the drugs stocked. This will be part of the business of the newly formed resuscitation group.

Emergency drugs, excluding cardiac arrest drugs, stocked in the Trust were discussed as follows:

- Adrenaline 1:1000 – two products are available in the Trust, ampoules and auto-injector. It was agreed that the Trust will stock the Epipen. The anaphylaxis procedure is currently under review.
- Chlorphenamine injection
- Hydrocortisone injection.
- Aspirin – for service users with chest pain will be considered for referral to the acute hospital
- Furosemide IV injection - JS recommended that this drug is not used by the Trust.
- Flumazenil – JS advised that in his professional opinion, this drug should not be stocked on inpatient wards. There is concern that if flumazenil is available on the wards, it could be administered incorrectly. Where it has been stocked on wards, it has been available for suitably trained medical and emergency staff to administer. JS highlighted that paramedics are not licenced to administer this drug. Currently the Trust does not consistently keep all the necessary equipment to administer intravenous injections on wards.

  Other Mental Health Trusts have debated the same issues; many of them do not feel confident about removing flumazenil and continue to stock it. The Resuscitation Council (UK) has strongly recommended that local decisions are determined by local policy and clinical need. NICE and CQC will be contacted for further clarification.

  Guidance will be sought to enable further discussion at the December meeting. **December agenda item.**
- Midazolam (buccal) – the Trust currently stocks rectal diazepam for seizures. The group agreed that buccal midazolam should be used instead. There is no procedure in the Trust on how to manage general seizures. There was a discussion about need for adequate awareness and training on buccal midazolam.

The Group agreed that the Trust should change to using buccal midazolam. Clear communication should be sent to all doctors, including junior doctors, advising them of this change. A full implementation plan would be needed to support this.
There was a discussion around whether this drug should be stored as a controlled drug. Pharmacy will consider where the drug should be stored – **December agenda item**

- **Salbutamol Nebuliser -** if a service user was so poorly, it would be more effective to have a nebuliser rather than an inhaler. Inhalers are routinely stocked on inpatient wards.

Further consultation on the draft paper prepared by JS is required.

Clozapine Procedure

Lead author TT summarised key points from the document for discussion and comment. Some minor edits are required. **Action TT to make amendments.**

The final document includes a summary guide which allows users to click onto the relevant links, to direct them to a section in the procedure, instead of trawling through the whole document.

The procedure covers the management of clozapine from initiation to cessation. It includes in-patient initiation (which is routine in AWP) but also sets out a new path way for initiation in the community. The procedure also highlights the importance of clear communication when service users move between settings (e.g from in-patient to community) so that there are no inadvertent breaks in treatment.

Drafting and peer revewing the procedure highlighted some differences in practice and some innovative approaches to the management of Clozapine. TT specifically sought the opinion of MOG regarding:

Myocarditis – An Australian study has shown that if weekly baseline troponin and CRP is measured for the first four weeks of treatment, instances of myocarditis could be picked up earlier. Should the troponin and CRP rise above certain levels, referral to cardiology is recommended.
There was a discussion around how this would work out for patients being titrated in the community in the areas that do not have clozapine clinics. In such cases close monitoring or a shared care procedure needs to be implemented.

Community Titration schedules - A decision was made after discussion at the Quality Forum in September to drop the standard two week re-titration schedule for community initiation (meaning the standard for a community titration would be three weeks). A line is to be added to the procedure to note that for community patients re-titrating following missed doses, a quicker (two week) bespoke titration could be used following consultation with pharmacy

The procedure is ratified. The final copy should be available in approximately three weeks and will be uploaded to OurSpace. **A communication is to be sent to all clinicians.**

Valproate Guideline

This guideline came as a response to the Dear Dr letter highlighting the risks of prescribing valproate to women of child bearing age. The guideline aims to highlight areas that need to be considered when using valproate and includes the responsibilities of the prescribing doctor and the pharmacy. It contains links to patient information and the checklist prescribers need to use to discuss the risks and obtain service user consent for treatment. The checklist should be signed and then be loaded onto RiO. The guideline recommends part of the prescriber's responsibility is to balance the risk, ensure the service user is aware of the risk and provide them with the information. Where there is a risk, the service user should be offered folic acid supplements as an option. When valproate is dispensed for women of child bearing potential, they should receive a patient card and valproate guide. Links to all the information are available in the document.

General information regarding valproate prescribing in the Trust

The Trust is using more Depakote than sodium valproate. There are no real clinical reasons for doing so. Finance provided an analysis over a 12 month period on the spend of Depakote against sodium

valproate. EY presented the graph which showed a saving of £41K if Epilim EC (sodium valproate) was used. It is recommended that no new service users are commenced on Depokate. Savings, dose for dose on 500mg would save approximately £200 per patient per year. The recommendation is to encourage prescribing sodium valproate, bearing in mind that the modified release/Chrono might be better tolerated. Clear documentation is needed on the medicine charts when valproate is prescribed, stating whether it is the Chrono or EC, otherwise by default the EC will be dispensed. The proposal is to prescribe sodium valproate where possible. If for any reason the service user prefers Depakote, the pharmacy will oblige, but it should be noted that it should not be used without good reason, and this must be fully documented in the service user's notes.

The guidance is ratified and to be uploaded to OurSpace.

CM raised a concern. She advised that a safety alert has previously been issued in the Trust; nursing staff were occasionally confusing the different preparations of valproate and administering them incorrectly. An alert will be sent out to clinical staff to raise awareness. Everyone needs to be signed up and be aware of the process.

JB suggested that a reasonable length of time be given for the information to be circulated and the transition made. January 2017 was agreed as the time to effect this change.

There is a plan to produce a pharmacy bulletin; the different valproate preparations will be highlighted in the bulletin.

MOG/16/06 Situation, Background, Assessment and Recommendations (SBAR)

Lithium monitoring

The North Somerset Locality Lead Pharmacist has been considering lithium monitoring in the locality with one of the doctors; IT support has been sought. There is concern about the lack of monitoring that is taking place. IT was approached to see whether it would be possible to have a local database set up to record patients. IT was going to look at this Trust-wide. The Acting Chief Pharmacist requested that an SBAR report be prepared to summarise the issues and consider all possible recommendations.

The results of the recent lithium POMH audit should be available December 2016 / January 2017. The results of the audit in 2013 were worse than the previous audits in 2010/2011. Some improvements are already being made: the AWP lithium procedure is being re-written; a separate SOP is being written for pharmacy staff to advise them on necessary checks when dispensing lithium; the shared care protocol is also being re-visited, around physical health monitoring.

There is a question over whose responsibility it is, and whether this lies with AWP or the GP.

The work being undertaken by SS will also look at whether lithium monitoring can be recorded in a specific designated area of RiO. Currently documentation is recorded in the progress notes**.**

MS mentioned that South Glos is looking at 'tagging' service users. They would be 'tagged' with a diagnosis and a medication. These would serve as alerts for monitoring.

Dr Naveen advised that there is concern around the reference levels; there is some confusion with GPs. Dr Fiona Harrison is considering lithium clinics in BANES.

The work detailed in the SBAR was endorsed by MOG.

CM – advised that going forward, the Medicines Incident Review Group (MIRG) will focus each month on particular issues. The November agenda is reviewing all recent lithium incidents reported in the Trust. CM will meet with Sally Squire to discuss the findings.

ECT use of methohexitone

RUH pharmacy developed a draft Standard Operating Procedure (SOP) around the supply of methohexitone to the Royal United when needed for ECT. Currently, RUH does not stock methohexitone. The SOP suggests AWP supplies the Methohexitone transports it to the RUH. The RUH will not keep unused methohexitone on site, and request that any remaining supply is either

destroyed, or returned to AWP. ECT leads would like methohexitone available for use.

There was a discussion on the practicalities for transporting drugs. RE asked for a proposal to be submitted to the December meeting for discussion**. Action SB**

Quantity of dispensed medicines given at discharge

Currently at discharge the Trust can be dispensing up to four weeks supply of medication. Pharmacy is proposing that routinely, a two week supply is dispensed.

The proposal is ratified. On discharge a two week supply of medication will routinely be supplied, unless it is clinically justified to supply more or less. With this change it was agreed that the immediate discharge letter should be changed from 28 days to 14 days. **Action VMcE**

It was agreed that an additional change will also be made, relating to continuation of treatment section on the discharge letter to clarify who is responsible to continue the medication. The immediate discharge letter will be amended to ensure greater clarity regarding this. **Action VMcE**

VMcE advised that in the New Year a piece of work will be commissioned to create an electronic discharge form.

MOG/16/07 Product Evaluation

Trevicta – three monthly paliperidone long acting injection

This is a new product that has come onto the market this year. EY provided a comparison to the monthly paliperidone. The patient should only be given the three monthly injections if they are stable on the monthly paliperidone. The group discussed how long the patient should stay on monthly paliperidone. The suggestion from the pharmacy is that they should stay on it for one year.

EY advised that there is no financial difference, but the saving will be on nurse resource and administration costs. If the three monthly paliperidone is put on the formulary, it is recommended to avoid error, to prescribe the two products as: **Paliperidone long acting injection (Trevecta)** and **Paliperidone long acting injection (Xeplion),** so that there is no confusion. It can be prescribed by any consultant as long as the patient has had a period of 12 months stable treatment on the monthly paliperidone. If a prescription is needed before the 12 months point, then the consultant should not prescribe it until it has been approved by the Medical Director and Chief Pharmacist, via the non-formulary drug request procedure. To enable pharmacy to monitor prescribing of Trevicta, it should only be ordered in-house, and not via Polarspeed.

Action: SB to contact Polarspeed to advise that no three monthly paliperidone is to be ordered via them.

Ratified, to be included in the formulary.

MOG/16/08 Formulary Application

Overview of approved non-formulary requests

EY provided a summary of requests that have come through the non-formulary process within the last few months (Jul, Aug and Sept):

Aripiprazole long acting injection: 15

Olanzapine depot: 2

Agomelatine: 3

Lurasidone: 2

Trihexyphenidyl: 1

Paliperidone (off-label): 1

Levomepromazine: 1

EY raised discussion about whether aripiprazole long acting injection should remain non-formulary. RE asked for a comparison around use to be presented at the December – **Action EY**

Addition of trihexphyenidyl and orphenadrine to formulary

EY submitted a proposal to add trihexyphenidyl to the Trust formulary. Only procyclidine is currently available for the management of extrapyramidal side effects (EPSEs) and that leaves little choice if the patient does not tolerate it. Procyclidine is available in oral as well as injectable formulations. Orphenadrine tablets have been discontinued but the oral solution is still available, but significantly more expensive.

Proposal: 1st line option Procyclidine

2nd line option Trihexphyenidyl

Orphenadrine remains as non-formulary

Ratified – Trihexyphenidyl as second line EPSE treatment option. Use for hypersalivation remains non-formulary.

MOG/16/09 Audits

LR presented two reports for approval by the group.

1. Q2 2016/17 Pharmacy Interventions – LR highlighted a couple of the interventions and noted there were a few in S Glos community where the charts required re-writing due to imminent expiry dates. There was a particular incident in Bristol which was picked up around a switch between Depixol and Clopixol depots. LR reinforced the aim of this report is to encourage learning and better prescribing through local review of the data. The group approved the report and recommendations.

2. Medicine Storage audit – LR fed back that most areas showed good compliance. LR highlighted the highest risk issue found in the audit related to the secure and labelled storage of schedule 4 CDs awaiting destruction. Also there were some issues relating to the security of keys. The group approved the report and the recommendations.

Re – Bristol incident (Depixol/Clopixol depots) – this is a training issue for the prescriber and should be raised as an incident. SB and CM to discuss in MIRG.

Action:LR to ensure guidance around incident reporting is clear when an amber or red intervention is recorded.

Action: LR to ensure audits are uploaded to OurSpace and circulated.

JB has arranged a medication management away-day with matrons and team managers. Some of the recommendations from the audits will be incorporated into the away-day.

Action: LR to liaise with JB.

MOG/16/10 Update on progress of on-going projects

Antimicrobial resistance e-learning

The development of the antimicrobial e-learning package is ongoing. It is hoped that by the December meeting, it will be peer reviewed and ready for ratification.

MOG/16/11 AOB

CM advised of a change to the Medicines Incident Review Group (MIRG) meetings, which are moving to more thematic reviews to share learning. This will necessitate a change of the MIRG Terms of Reference. CM will bring the ToR to the November MIRG for approval**. (December agenda)**

Discussion around prescribing of melatonin which is non-formulary. It has been highlighted that GPs are not happy to prescribe it. TT advised that this would go to the local formulary meetings for discussion.

MOG/16/17 Dates of Future Meetings

15th December, 1.30pm-3.30pm Maple Room, Jenner House, Chippenham